



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP, PA
8108 FOX CREEK TRAIL
DALLAS TX 75249

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-10-5321-01

MFDR Date Received

AUGUST 26, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier failed to provide the original response EOB's... The carrier has also failed to provide any request for reconsideration response EOBs... A '10 DAY DEMAND FOR RFR EOBs' was sent via fax on 8/13/10 requesting all of the above EOB's with no response from the carrier. The carrier has not sent proof that the request was completely considered and therefore did not properly comply with our request. The HCP who has worked very hard to provide important and pre-authorized services to our patient and now must work even harder trying to get PAID BY THE CARRIER for properly performing pre-authorized services. The HCP now expects the carrier to continue to refuse to present proper EOB's, but sometime in the future the carrier's agent will send a simple letter to TDI and claim, without any EOB substantiation, that all services provided were denied as not medically necessary. Such methodology is the carrier's only tool to assure their claimants get the help they require to get better and return to work, but at the same time successfully work to avoid making payments and to put qualified HCP's out of business. This HCP beseeches the TDI to rule on this Fee Dispute based on the existing EOB's presented by the carrier to the HCP, along with all the other properly submitted documentation."

Amount in Dispute: \$3,599.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As referenced in the my response of November 11, 2010, the preauthorized physical therapy and work hardening was resubmitted to bill review for processing and, if appropriate, payment pursuant to the MAR. The review has been completed and, except for DOS 11-5-09, payment has been authorized. I have attached hereto as Exhibit 'A' copies of the checks and supporting EOBs for the preauthorized physical therapy and work hardening."

Response Submitted by: Lewis & Backhaus, PC, 14160 Dallas Parkway 400, Dallas, TX 75254

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
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August 31, 2009, September 1, 2009, September 9, 2009, September 23, 2009, September 25, 2009, September 28, 2009, September 29, 2009, October 2, 2009, October 5, 2009, October 12, 2009, October 13, 2009, October 14, 2009, October 19, 2009, October 22, 2009, October 23, 2009, October 26, 2009, December 29, 2009	CPT Code 99213 (53.68 ÷ 36.0666) x 58.11 = \$86.49 x 18 Units =	\$1,654.56	\$1,556.79
September 1, 2009	CPT Code 73110	\$49.68	\$44.81
September 15, 2009	CPT Code 95831	\$75.58	\$69.90
September 15, 2009	CPT Code 95832 x 2	\$71.42	\$66.44
September 14, 2009, October 19, 2009, December 29, 2009	CPT Code 99080-73	\$45.00	\$30.00
October 5, 2009	CPT Code 97110 (4 Units)	\$168.88	\$159.73
October 5, 2009	CPT Code 97112	\$43.24	\$40.77
October 5, 2009	CPT Code 97140	\$38.94	\$36.87
November 2, 2009	CPT Code 99212	\$55.71	\$51.82
November 9, 2009	CPT Code 97750-FC (16 Units)	\$692.80	\$653.92
December 9, 2009	CPT Code 97750-FC (8 Units)	\$346.40	\$326.96
December 2, 2009	97546-WH (6 Units) (6 hrs x \$64.00/hr = \$384.00 x 80%)	\$307.20	\$307.20
February 8, 2010	CPT Code 99455-VR	\$50.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 and §134.204 sets out the procedures for reimbursement.
3. 28 Texas Administrative Code §129.5 sets out the procedures for Work Status Reports (DWC-73).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 29, 2009, December 9, 2009, March 20, 2010, March 31, 2010, August 10, 2010, August 13, 2010, and August 16, 2010

- 1 (50) (XA53)– These are non-covered services because this is not deemed a 'medical necessity' by the payer
- W1 – Workers Compensation State Fee Schedule Adjustment.

- 96 – Non Covered Charges.
- Z710 – The charge for this procedure exceeds the fee schedule allowance.
- M282 – Procedure reimbursable only when billed in conjunction with primary procedure on same date of service.
- 1 – Unrelated to the compensable injury

Issues

1. Did the denials of medical necessity meet the requirements of 28 Texas Administrative Code §133.307(d)(2)(E)?
2. Was a PLN-11 filed for the extent of injury denial?
3. Did the requestor file the request for medical fee dispute resolution according to 28 Texas Administrative Code §133.307? Did the requestor file the Work Status Report in accordance with 28 Texas Administrative Code §129.5?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the services in dispute as “1 (50) (XA53) – These are non-covered service because this is not deemed a ‘medical necessity’ by the payer. 28 Texas Administrative Code §133.307(d)(2)(E) states that if the medical fee dispute involves medical necessity issues, the carrier shall attach a copy of the documentation that supports and adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review). The insurance carrier did not meet the requirements of the rule; therefore the disputed dates of service are eligible for review by Medical Fee Dispute Resolution.
2. The insurance carrier denied some services as “1 – Unrelated to the compensable injury.” Review of the documentation submitted by the parties and the Divisions TXCOMP system shows that the insurance carrier did not file a PLN-11; therefore the insurance did not support the denial reason and the services/treatment are eligible for review.
3. The requestor has met the requirements of 28 Texas Administrative Code §133.307; therefore, the dispute is eligible for review in accordance with 28 Texas Administrative Code §134.203(c)(1-2) and §134.204.
 - Review of clinical notes submitted by the requestor supports the services were rendered as billed for CPT Code 99213 for dates of service August 31, 2009 through December 29, 2009; therefore, reimbursement is recommended.
 - Review of clinical notes for date of service September 1, 2009 supports the requestor had one X-Ray view taken of the injured employee’s right wrist, CPT Code 73110; therefore reimbursement is recommended.
 - Review of clinical notes for date of service September 15, 2009 supports the requestor performed manual limb muscle testing (CPT Code 95831) and manual hand muscle testing (CPT Code 95832; 2 units); therefore reimbursement is recommended.
 - The requestor submitted Work Status Reports (DWC-73) for dates of service September 15, 2009, October 19, 2009, and December 29, 2009. Per 28 Texas Administrative Code §129.5(d) the doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee’s work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor’s schedule appointments with the employee. In accordance with §129.5(a)(3), review of the submitted Work Status Reports shows no change of work status on the reports of September 15, 2009 and October 19, 2009; the work status report of December 29, 2009 show the work status changed allowing the employee to return to work as of December 29, 2009. Therefore, documentation submitted supports reimbursement for the reports of September 15, 2009 and December 29, 2009.
 - In accordance with 28 Texas Administrative Code §134.204(g) the requestor submitted billed for two FCE’s for dates of service November 9, 2009, as an initial FCE, and December 9, 2009, as the exit FCE. Review of the submitted FCE reports for both dates of service supports the services were rendered and billed; therefore reimbursement is recommended.
 - CPT Code 97546-WH, for date of service December 2, 2009, was a preauthorized treatment. The insurance carrier paid the first hour billed under CPT Code 97545-WH however denied the disputed

code using "M282 – Procedure reimbursable only when billed in conjunction with primary procedure on same date of service. The insurance carrier did not support their denial. In accordance with 28 Texas Administrative Code §134.204(h)(1)(B), if the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. Per 28 Texas Administrative Code §134.204(h)(3)(B) reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. The requestor billed six (6) hours. Review of the work hardening notes shows that the treatment was rendered as billed; therefore reimbursement is recommended.

- The requestor billed CPT Code 99455-VR on February 8, 2010. In accordance with 28 Texas Administrative Code §134.204(j)(6) the treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50. Review of the submitted documentation reveals that there was no documentation submitted for this date of service. Therefore, reimbursement is not recommended.

4. Review of the submitted documentation finds that requestor is due reimbursement for CPT Codes 99213, 73110, 95831, 95832, 99080-73 (two reports), 97110, 97112, 97140, 99212, 97750-FC and 97546-WH.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,345.21.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,345.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 14, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.